IV. CLAIMS REVIEW

A. Jurisdiction Determination

In the early stages of claims review, the contractor shall determine that claims received are within its contractual jurisdiction using the criteria in Section II of this chapter. The contractor shall handle all claims involving billings outside its jurisdiction as follows:

1. Out-of-Jurisdiction TRICARE Claims

Including those to be processed by TRICARE Management Activity (TMA) and--under the TRICARE Prime Remote (TPR) Program--dental claims to be processed by the Service Points of Contact (SPOCs) listed in OPM Part Three, Chapter 8, Addendum A .

a. Totally Out-of-Jurisdiction

When a contractor receives a claim with no services or supplies within its jurisdiction, it shall clearly indicate the original date of receipt on the claim. The contractor shall then forward the claim and supporting documentation to the appropriate contractor(s) within 72 hours of identifying it as being out-of-jurisdiction. All contractors shall include current information on the beneficiary and family deductible and catastrophic loss amounts, if any, shown as accumulated on the history file. The transferring contractor shall also inform the claimant of the action taken and provide the address of the contractor to which the claim was forwarded. (See Figure 2-1-A-4 of this chapter for suggested language.)

b. Partially Out-of-Jurisdiction

When a contractor receives a claim for services or supplies both within and outside its jurisdiction before processing the services or supplies within its jurisdiction, and within 72 hours of identifying the out-of-jurisdiction items, the contractor shall:

(1) Draw lines through the in-jurisdiction items.

(2) Ensure the original date of receipt is clearly indicated on the claim.

(3) Send a copy of the claim and all supporting documents to the appropriate contractor(s).

(4) *Reserved*

(5) As required in Section IV.A.1.a., above, the contractor shall include information on deductible and catastrophic loss amounts accumulated.

(6) If more than one other contractor is involved, the transferring contractor shall provide each the name(s) of the other(s). The transferring contractor shall notify the claimant of the action taken and provide the address(es) of the contractor(s) to which the claim was forwarded. In addition, the contractor shall briefly explain the potential for application of excessive deductible for outpatient services due to the involvement of more than one contractor in the processing of the one claim and the procedures to follow should this occur. (See Figure 2-1-A-5 for suggested language.)

2. Non-TRICARE Claims

a. CHAMPVA Claims

When a claim is identified as a CHAMPVA claim, the contractor shall *return the claim to the sender with a letter advising them that the CHAMPVA Program's toll-free telephone number 1-800-733-8387, and instruct them to send the claim and all future CHAMPVA claims to:*

Health Administration Center
CHAMPVA Program
P.O. Box 65024
Denver, Colorado 80206-9024

b. Supplemental Health Care Program (SHCP)

(1) Services Prior to Implementation of the Revised Supplemental Health Care Program

(a) The contractor shall price supplemental health care claims forwarded by MTF/MMSO claims offices in accordance with the requirements in OPM Part Three, Chapter 9 and Chapter 10.

(b) The contractor shall forward any other SHCP claims (i.e., those not forwarded for pricing by the MTF/MMSO claims offices) to the appropriate Uniformed Services, within 72 hours of identification as a non-TRICARE claim. Contractors shall use the active duty service member's branch of service and the geographic location where the services were provided to determine that proper point of referral, using OPM Part Three, Chapter 9 and Chapter 10. Active duty SHCP claims are usually identified by the information in the service block and relationship block, e.g., status: "active duty" and relationship: "self." Contractors shall not return these claims to the claimant nor enter them into the processing system but shall notify the claimant of the action taken. (See Figure 2-1-A-6 of this chapter for suggested wording.) (See OPM Part Three, Chapter 9 and Chapter 10 for additional details.)

(2) Services on or after Implementation of the Revised Supplemental Health Care Program

(a) See OPM Part Three, Chapter 9 for requirements for processing active duty and other SHCP claims which are for civilian services pursuant to an MTF referral.

(b) See OPM Part Three, Chapter 10 for requirements for processing active duty and any other supplemental health care claims which are for civilian services but not pursuant to an MTF referral.

c. Claims for Other Ineligible Beneficiaries

(1) Veterans Claims

If a claim is received for care of a veteran and there is evidence the care was ordered by a VA physician, the claim, with a letter of explanation, shall be sent to the VA institution from which the order came. The claimant must also be

sent a copy of the letter of explanation. If there is no clear indication that the VA ordered the care, return the claim to the sender with an explanation that the veteran is not eligible under TRICARE and that the care ordered by the VA should be billed to the VA.

(2) Parents and Parents-In-Law, Grandchildren, and Others

On occasion, a claim may be received for care of a parent or parent-in-law, a grandchild, or other ineligible relative of a TRICARE sponsor. Return the claim to the claimant with a brief explanation that such persons are not eligible for TRICARE benefits.

(3) Other Non-TRICARE Claims

The contractor shall return claims submitted on other than approved TRICARE claim forms to the sender or transfer to other lines of business, if appropriate.

B. *Reserved*

1. *Reserved*

2. *Reserved*

3. *Reserved*

a. *Reserved*

b. *Reserved*

(1) *Reserved*

(a) *Reserved*

(b) *Reserved*

(c) *Reserved*

(d) *Reserved*

(2) *Reserved*

(a) *Reserved*

(b) *Reserved*

1 *Reserved*

2 *Reserved*

(3) *Reserved*

(a) *Reserved*

(b) *Reserved*

(4) ***Reserved***

(5) ***Reserved***

(a) *Reserved*

(b) *Reserved*

(c) *Reserved*

c. ***Reserved***

(1) *Reserved*

(2) *Reserved*

(a) *Reserved*

(b) *Reserved*

(c) *Reserved*

C. Time Limitations on Filing TRICARE Claims for Services or Supplies Provided on or after January 1, 1993

All TRICARE claims for benefits must be filed with the appropriate TRICARE contractor no later than one *(1)* year after the date the services were provided *or one (1) year from the date of discharge for an inpatient admission for facility charges billed by the facility. Professional services billed by the facility must be submitted within one year from the date of service*.

1. *Reserved*

2. *Reserved*

EXAMPLE:

For Service or Discharge	Must be Received by the Contractor
March 22, *1999*	No later than March 22, *2000*
December 31, *1999*	No later than December 31, *2000*

3. Written Request (Other than a Claim Form) for TRICARE Benefits "Within" the Claims Filing Deadline

Any written request for benefits, whether or not on a claim form, shall be accepted for determining if the "claim" was filed on a timely basis. However, when other than an approved claim form is first submitted, the provider shall be notified that only an approved TRICARE claim form is acceptable for processing a claim for benefits. The contractor shall inform the provider in writing that in order to be considered for benefits, an approved TRICARE claim form and any additional information (if required) must be submitted and received by the contractor no later than one *(1)* year from the date of service or date of discharge, or ninety (90) calendar days from the date they were notified by the

contractor, whichever is later. The provider should submit claims on either the HCFA Form 1500 or the UB-92, as appropriate.

4. Exceptions to Filing Deadline

a. *Reserved*

b. *Reserved*

c. *Reserved*

(1) Retroactive Determinations

In order for an exception to be granted based on a retroactive determination, the retroactive determination must have been obtained/issued after the timely filing period elapsed. If a retroactive determination is obtained/issued within one *(1)* year from the date of service/discharge, the one *(1)* year timely filing period is still binding.

(a) Only the Uniformed Services or the Department of Veterans Affairs may determine retroactive eligibility. Once a retroactive eligibility determination is made, an exception to the claims filing deadline shall be granted. A copy of the retroactive eligibility decision must be provided. In any case where a retroactive "preauthorization" determination is made to cover such services as the Program for Persons with Disabilities, adjunctive dental care, surgical procedures requiring preauthorization, etc., the timely filing requirements shall be waived back to the effective date of the retroactive authorization. Claims which are past the filing deadline must, however, be filed not more than *one hundred eighty (*180*)* days after the date of issue of the retroactive determination.

(b) For purposes of granting an exception, retroactive issuance of a Nonavailability Statement shall be treated as retroactive eligibility.

(2) Administrative Error

(a) If an administrative error is alleged, the contractor shall grant an exception to the claims filing deadline only if there is a basis for belief that the claimant had been prevented from timely filing due to misrepresentation, mistake or other accountable action of an officer or employee of TMA (including TRICARE Overseas) or a contractor, performing functions under TRICARE and acting within the scope of that individual's authority.

(b) The necessary evidence shall include a statement from the claimant, regarding the nature and affect of the error, how he or she learned of the error, when it was corrected, and if the claim was filed previously, when it was filed, as well as one of the following:

1 A written report based on agency records (TMA or contractor) describing how the error caused failure to file within the usual time limit, or

2 Copies of an agency letter or written notice reflecting the error.

NOTE:

The statement of the claimant is not essential if the other evidence establishes that his or her failure to file within the usual time limit resulted from administrative error, and that he or she filed a claim within ninety (90) calendar days after he or she was notified of the error. There must be a clear and direct relationship between the administrative error and the late filing of the claim. If the evidence is in the contractor's own records, the claim file shall be annotated to that effect.

(3) Inability to Communicate and Mental Incompetency

(a) For purposes of granting an exception to the claims filing deadline, mental incompetency includes the inability to communicate even if the result of a physical disability. A physician's statement, which includes dates, diagnosis(es) and treatment, attesting to the beneficiary's mental incompetency shall accompany each claim submitted. Review each statement for reasonable likelihood that mental incompetency prevented the person from timely filing.

(b) If the failure to timely file was due to the beneficiary's mental incompetency and a legal guardian had not been appointed during the period of time in question, the contractor shall grant an exception to the claims filing deadline based on the required physician's statement. (See above.) If the charges were paid by someone else, i.e., spouse or parent, request evidence from the spouse or parent that the claim was paid and by whom. When the required evidence is received, make payment to the signer of the claim, with the check made out: "Pay to the order of (spouse's or parent's name) for the use and benefit of (beneficiary's name)."

(c) If a legal guardian was appointed prior to the timely filing deadline and the claims filing deadline was not met, an exception cannot be granted due to mental incompetency of the beneficiary.

(4) Provider Billings

A written request for an exception to the claims filing deadline must be submitted by the participating provider only when the claim is changed from nonparticipating to participating. No written request is required on a participating claim.

(5) Other Health Insurance (OHI)

(a) The contractor may grant exceptions to the claims filing deadline requirements, if the beneficiary submitted a claim to a primary health insurance, i.e., double coverage, and the OHI delayed adjudication past the TRICARE deadline.

(b) These claims must have been originally sent to the OHI prior to the TRICARE filing deadline or must have been filed with a TRICARE contractor prior to the deadline but returned or denied pending processing by the OHI.

(c) The beneficiary must submit with the claim a statement indicating the original date of submission to the OHI, and date of adjudication,

together with any relevant correspondence and an Explanation of Benefits or similar statement.

(d) The claim form must be submitted to the contractor within ninety (90) days from the date of the OHI adjudication.

(6) *Reserved*

D. Time Limitations for Exceptions to the Claims Filing Deadline

1. There is no time limit stipulated for submitting written requests for exceptions to the claims filing deadline before a claim has been submitted. However, after the proper claim has been submitted and an exception to the claims filing deadline granted, the contractor is authorized to consider for benefits only those services or supplies received during the six (6) years immediately preceding the receipt of the request. Services or supplies claimed for more than six (6) years immediately preceding the receipt of the request shall be denied.

2. If an contractor receives a request for an exception to the filing deadline, but a completed claim form is not enclosed, the contractor shall:

a. Inform the claimant of the requirement that an approved TRICARE claim form must be completed and submitted before benefits may be considered,

b. Advise the claimant that the claim and supporting documentation must be resubmitted within ninety (90) calendar days from the date of the contractor's letter, and

c. Provide the beneficiary with appropriate forms.

E. *Reserved*

1. *Reserved*

a. *Reserved*

b. *Reserved*

(1) *Reserved*

(2) *Reserved*

(3) *Reserved*

(4) *Reserved*

2. *Reserved*

a. *Reserved*

b. *Reserved*

c. *Reserved*

3. *Reserved*

a. *Reserved*

b. *Reserved*

c. *Reserved*

4. *Reserved*

a. *Reserved*

b. *Reserved*

c. *Reserved*

d. *Reserved*

e. *Reserved*

f. *Reserved*

g. *Reserved*

5. *Reserved*

a. *Reserved*

b. *Reserved*

6. *Reserved*

a. *Reserved*

b. *Reserved*

F. Signature Requirements

1. Beneficiary, Spouse, Parent or Guardian Signature

To require release of needed information and to protect resources, it is usually necessary to have proper signatures on claims. *The* contractor shall comply with the state law and with the corporate policy applied for requiring signatures on their private business claims in establishing signature requirements for at-risk TRICARE claims. However, when the private or state signature requirements conflict with federal Privacy Act or freedom of information requirements, the latter shall prevail. *The* contractor must comply with the following requirements in processing non-network TRICARE claims for which the signature of the beneficiary, spouse, or parent or guardian of a beneficiary is required unless qualifying for an exception. If additional personal information or release of medical information is required to complete claim processing, the claim should be returned to the

beneficiary for his/her signature, unless the beneficiary is not competent. The procedures below are basic guidelines, but are not mandatory requirements unless so indicated.

a. Privacy Act Requirements

Any relaxation of signature requirements does not, in any way, relax the confidentiality requirement imposed by the Privacy Act. Checks, Explanations of Benefits (EOBs), responses to inquiries, etc., shall be addressed to the beneficiary or parent or guardian of a beneficiary who is incompetent or under eighteen (18) years of age. Under the provisions of the Privacy Act of 1974, neither TMA nor a claims processor shall provide the noncustodial parent with any information concerning the processing of TRICARE claims for the minor children without the written consent of the custodial parent. In the case of divorce or legal separation only the custodial parent shall have access to the medical record(s), unless the divorce or legal separation decree gives rights to the records to the noncustodial parent. Questions regarding custodial parent issues should be addressed to the TMA Office of General Counsel.

b. Beneficiary is Under Eighteen (18) Years of Age

(1) *Nonparticipating Provider Claims*

Normally, the claim should be signed by the parent or legal guardian if the beneficiary is under eighteen (18) years of age. However, if the beneficiary signs the claim form legibly , the claim should be processed unless there is other reason to return the claim form, or doing so conflicts with state law or contractor policy. Request the parent/legal guardian signature, if the claim form is returned except for the two exceptions listed below. In the following situations, a beneficiary under eighteen (18) years of age may always sign the claim form in his or her own behalf in accord with state laws related to the age of consent and the Federal Privacy Act. Exceptions:

(a) *He or she is (or was) a spouse of an active duty service member or retiree; or*

(b) *The services are related to venereal disease, drug or alcohol abuse, or abortion.*

(2) *Participating Provider Claims*

If a claim is signed by a beneficiary who is under 18 years of age but the provider agrees to participate, it is not necessary to obtain the signature of the parent/legal guardian.

c. Beneficiary is Eighteen (18) Years of Age or Older (Incompetent or Incapable)

When the beneficiary is mentally incompetent or physically incapable, the person signing should be either the legal guardian, or in the absence of a legal guardian, a spouse or parent of the patient. The person signing should:

(1) Write the beneficiary's name in the appropriate space on the claim form, followed with the word "by" and his or her own signature;

(2) Include a statement that a legal guardian has not been appointed, if such is the case; and

(3) Include documentation of appointment if a legal guardian has been appointed or if a power of attorney has been issued. Attach a statement giving his or her full name and address, relationship to the patient, and the reason the patient is unable to sign. Beneficiaries who have no legal guardian or family member available to sign claims, can provide documentation (i.e., a report from a physician describing the physical and or mental incapacitating illness). For those conditions/illnesses which are temporary, the signature waiver needs to specify the inclusive dates of the condition/illness.

(4) A beneficiary who is physically incapable of signing their signature can have a general or limited power of attorney issued by having their "mark" (e.g., an "X") witnessed and notarized.

d. Beneficiary Deceased

If the provider of care has an approved signature on file agreement and the beneficiary expires, the authorization for payment will satisfy the signature requirements and the contractor shall process the claim.

(1) If the beneficiary is deceased, the claim form must be signed by the legal representative of the estate. Documentation must accompany the claim form to show that the person signing is the legally appointed representative. If no legal representative has been appointed, the claim form may be signed by the parent, the spouse, or the next of kin. The signer must provide a statement that no legal representative has been appointed. The statement should contain the date of the beneficiary's death and the signer's relationship to the beneficiary to enable the contractor to update the history file.

(2) In the event that there is no spouse, parent or guardian to sign the claim form for a deceased beneficiary, the claim must be signed by the surviving next of kin or a legally appointed representative (indicate relationship to beneficiary).

(3) When there is no spouse, parent or guardian to sign the claim form for a deceased beneficiary, no next of kin, and no legal representative, the contractor shall arrange to pay the provider whether network or non-network for services rendered in accord with state law and corporate policy.

e. Signatures Which Are Not Acceptable

A provider or an employee of an institution providing care to the patient may not sign the claim form on behalf of the beneficiary under any circumstances. Nor can an employee of a contractor execute a claim on behalf of a beneficiary (unless such employee is the beneficiary's parent, legal guardian, or spouse). Beneficiaries who have no legal guardian or family member available to sign claims, can provide documentation (i.e., a report from a physician describing the physical and/or mental incapacitating illness). For those conditions/illnesses which are temporary, the signature waiver needs to specify the inclusive dates of the condition/illness. If the beneficiary is unable to sign due to an incapacitating condition/illness, the provider can annotate in the Signature Box on the TRICARE claim form "Unable to sign." A letter from the provider shall be attached to the claim form describing the physical and or mental incapacitating illness. For those illnesses which are temporary, the letter needs to specify the inclusive dates of the illness.

f. Verification of Provider's Compliance with the Beneficiary Signature on File Requirement

The contractor shall verify beneficiary signature on file compliance using the postpayment audit requirement in the OPM Part One, Chapter 1, Section IV.D., and the audit procedures in OPM Part Two, Chapter 7, Section IV.C.

(1) Institutional Claims

(a) All claims related to an institution

(b) Outpatient hospital, professional inpatient and outpatient hospital services for release of information purposes, the provider must obtain the beneficiary or other authorized signature on a permanent hospital admission record for each separate inpatient admission. A professional provider submitting a claim related to an inpatient admission must indicate the name of the facility maintaining the signature on file. Claim forms must indicate that the signature is on file.

(2) Professional Provider Claims

Outpatient professional such as physician's office and suppliers such as Durable Medical Equipment (DME). Authorized individual providers have the option to retain on their own forms appropriate beneficiary release of information statements for each visit or obtain and retain in his or her files a one-time payment authorization applicable to any current and future treatment that the physician may furnish him or her. Claim forms must indicate that the signature is on file.

g. *Claims for Certain Ancillary Services - Administrative Tolerance*

(1) *Claims for inpatient anesthesia, laboratory and other diagnostic services in the amount of $50 or less, provided by physician specialists in anesthesiology, radiology, pathology, neurology and cardiology should not be returned for beneficiary signature unless required by state law or contractor corporate policy.*

(2) *Claims submitted by an institution when the claim is for those specific ancillary services cited in above, should be included in this tolerance it the services where performed in an institution other than the institution in which the beneficiary is receiving inpatient care.*

(3) Outpatient Ancillaries

(a) Such as independent laboratory where, ordinarily, no patient contact occurs

(b) A provider submitting a claim for diagnostic tests or test interpretations, or other similar services, is not required to obtain the patient's signature. These providers must indicate on the claim form: "patient not present." For services when there is patient contact such as services furnished in a medical facility which is visited by the beneficiary, the same procedure used for professional claims for outpatient services is required, except that the provider will indicate along with "signature on file" information, the name of the supplier or other entity rather than a physician maintaining the signature on file.

(4) Use of the signature on file procedure is the provider's indication that he or she agrees to the following requirements:

(a) Verification of the beneficiary's TRICARE eligibility at the time of admission or at the time care or services are provided.

(b) Incorporation of the language below, or comparable language acceptable to the TRICARE contracts, into the provider's permanent records.

1 Institutional Providers

"I request payment of authorized benefits to me or on my behalf for any services furnished me by (***Name of Provider***), including physician services. I authorize any holder of medical or other information about me to release to (***Contractor's Name***) any information needed to determine these benefits or benefits for related services." Professional providers who submit claims on the basis of an institution's signature on file should include the name of the institutional provider that maintains the signature on file. The UB-92 instructions shall be followed for certifying signature on file except that the permanent hospital record containing a release statement will be recognized.

2 Professional Provider Claims

"I request that payment of authorized benefits be made either to me or on my behalf to Dr._____, for any services furnished me by that physician. I authorize any holder of medical information about me to release to ***(Contractor's Name)*** any information needed to determine these benefits or the benefits payable for related services."

(c) If a claim is submitted by a nonparticipating provider and payment will not be made to the patient, the provider must indicate the name, address and relationship of the person to whom payment will be made. This will be the sponsor, other parent or a legal guardian for minor children or incompetent beneficiaries, except for claims involving abortion, venereal disease or drug/alcohol abuse.

(d) Cooperate with contractor postpayment audits by supplying copies of the requested signature(s) on file within *twenty-one (*21*)* days of the date of the request and/or allow the contractor access to the signature files for purposes of verification. (See OPM Part One, Chapter 1, Section IV.D.1., and OPM Part Two, Chapter 7, Section IV.C., for audit requirements.)

(e) Correct any deficiencies found by the contractor audit within *sixty (*60*)* days of notification of the deficiency or participation in the signature relaxation program will be terminated.

(5) Other Claims

Requirements for a beneficiary's (sponsor, guardian or parent) signature should be waived in the following situations for claims received from non-network participating providers. *The* contractor should grant a waiver after the procedures described below have proven unsuccessful.

(a) Beneficiary (Sponsor, Guardian or Parent Moved) Unable to Locate

If unable to obtain a signature because the beneficiary has moved and left no forwarding address, the contractor shall attempt to obtain the address by telephone or from internal files. *The* contractor who *has* on-line access to DEERS screens providing sponsor or beneficiary's addresses may use DEERS. If a new address is obtained, the original claim should be returned to the beneficiary or sponsor with a request for signature. If the claim was submitted by a provider, a **copy**, with the diagnosis and any sensitive information deleted, shall be sent to the beneficiary or sponsor. If the signature is not obtained because the new address is still not valid and the patient cannot be otherwise located, the contractor should grant a signature waiver for a participating provider. Nonparticipating provider claims must be denied. However, if the address is valid, and the contractor knows, through the claim development process, that the beneficiary or sponsor does not wish to file a claim, the claim(s) must be denied whether or not the provider participates.

NOTE:

If the contractor obtains a new address, this address cannot be released to the provider.

(b) *Reserved*

(c) *Reserved*

(d) *Reserved*

2. Provider Signature

a. *Network*

Signature requirements for network providers are dependent upon the provisions of the agreement and administrative procedures established between the providers and the contractor.

b. *Non-Network*

The signature of the *non-network* provider*, or an acceptable facsimile, is* required on all participating claims. *If a non-network participating claim does not contain an acceptable signature, return the claim*. The provider's signature *is also* required to certify services rendered when a provider completes a nonparticipating claim for the beneficiary. *If the provider does not sign, the contractor may contact the provider by telephone to verify the delivery of services or return the claim for signature. A claimant may also attach an itemized bill on the letterhead/billhead of the provider verifying delivery of services*.

c. Facsimile or Representative Signature Authorization

In lieu of a provider's actual signature on a TRICARE claim, a facsimile signature or signature of a representative should be accepted if the contractor has on file a notarized authorization from the provider for use of a facsimile signature (Figure 2-1-A-8) or a notarized authorization or power of attorney for another person to sign on his or her behalf (Figure 2-1-A-9). The facsimile signature may be produced by a

signature stamp or a block letter stamp, or it may be computer-generated, if the claim form is computer-generated. The authorized representative may sign using the provider's name followed by the representative's initials or using the representative's own signature followed by "POA" (Power of Attorney), or similar indication of the type of authorization granted by the provider.

d. Verification of Signature Authorization

In the absence of any indication to the contrary, contractors should assume the proper authorization is on file, validating through file checks, those claims containing facsimile and representatives' signatures which are included in their quality control audit, and program integrity samples. *The* contractor should remind providers of the requirement for current signature authorizations through at least annual notice in routine bulletins or newsletters and at other appropriate times when contacts are made. The contractor may *return a claim with a request for the signature authorization* when it is found that there is no authorization on file or it is out-of-date:

(1) Send a request to the provider advising of the need for authorization and;

(2) Set a utilization flag on the provider's file to stop further payment to the provider when the proper signature is not on the claim, pending receipt of the authorization.

(3) Advise the provider that if the authorization is not received, it will be necessary to deny the claim or to process it as a nonparticipating claim, depending on the information available to make a payment determination.

(4) Schedule a contractor representative visit to resolve any problem which may develop in the unlikely event a provider chooses not to cooperate.

e. *Certification of Source of Care*

Source of care certification is used to help determine the correct payee on the participating UB-92 and the HCFA 1500. If signed by the provider and the certification is unaltered, issue payment to that provider. If signed with alteration of the certification, issue payment to the beneficiary (parent/legal guardian of minor or incompetent). If unsigned and an itemized billing on the provider's letterhead is not attached, return the claim.

NOTE:

For procedures in case of any irregularities, refer to OPM Part Two, Chapter 7, Program Integrity.

G. *Reserved*

1. *Reserved*

a. *Reserved*

(1) ***Reserved***

b. *Reserved*

c. *Reserved*

(1) *Reserved*

(2) *Reserved*

(3) *Reserved*

(4) *Reserved*

(5) *Reserved*

(6) *Reserved*

(7) *Reserved*

(8) *Reserved*

d. *Reserved*

(1) *Reserved*

(2) *Reserved*

(3) *Reserved*

(4) *Reserved*

(5) *Reserved*

(6) *Reserved*

(7) *Reserved*

(8) *Reserved*

(9) *Reserved*

(10) *Reserved*

e. *Reserved*

(1) *Reserved*

(2) *Reserved*

(3) *Reserved*

(4) *Reserved*

f. *Reserved*

g. *Reserved*

2. *Reserved*

a. *Reserved*

b. *Reserved*

c. *Reserved*

(1) *Reserved*

(a) *Reserved*

(b) *Reserved*

(2) *Reserved*

(3) *Reserved*

(4) *Reserved*

(5) *Reserved*

(6) *Reserved*

(7) *Reserved*

d. *Reserved*

e. *Reserved*

(1) *Reserved*

(2) *Reserved*

(3) *Reserved*

(4) *Reserved*

(5) *Reserved*

H. Authorizations

1. *Reserved*

a. *Reserved*

b. *Reserved*

2. General Benefit Requirements

a. Authorization is required before benefits may be extended for *all inpatient mental health care (including RTC, SUDRF, and PHP); adjunctive dental care; all care under the Program for Persons with Disabilities; and outpatient psychoanalysis and mental*

health care after eight (8) visits. The contractor processes all requests for such authorization from beneficiaries residing within its jurisdiction. Because of the high risk that many services requiring special authorization may be denied, the contractor is required to offer preauthorization for the care to all TRICARE beneficiaries who reside within its jurisdiction.

b. The contractor will issue notification of preauthorization/authorization or waiver to the beneficiary or parent/guardian of a minor or incompetent, the provider, and to its claims processing staff. Notification may be by letter, or on a form developed by the contractor. For the purposes of this manual, these forms and letters are all referred to as TRICARE authorization forms.

c. *The* contractor must maintain an automated authorization file or an automated system of flagging to ensure claims are processed consistent with authorizations. Authorization data or flags must be posted and/or set within five (5) work days of issue of the authorization. *The* contractor shall verify that the beneficiary, sponsor, provider, and service or supply information submitted on the claim are consistent with that authorized and that the care was accomplished within the authorized time period.

d. *Reserved*

e. If a claim for the types of care in Section IV.H.2.a., above, is submitted without a copy of the authorization and a copy is not on file, the contractor should deny the claim. If the contractor chooses to place added authorization/preauthorization controls on network providers, it may do so. However, the TRICARE beneficiary must be "held harmless" in cases where the network provider fails to request authorization for care and the contractor denies payment, unless the beneficiary makes an informed decision *in writing* to receive and pay for the care which has not been pre-authorized. *(*OPM Part Three, Chapter 1, Section I.B.2.b.(2).*)*

f. In those instances where a contractor offers voluntary authorization of services in addition to those listed above, such authorization must be available to and appealable by all beneficiaries, whether enrolled or not.

g. *Clarification of authorization shall be made with the contractor benefit authorization unit, if necessary, If the data on the claim clearly does not match the authorization, and if the discrepancy cannot be resolved by contact with the authorizing unit, deny the claim*.

3. Hospice Programs

Network hospice providers must seek prior authorization from the Health Care Finder (HCF) for each election period (refer to Policy Manual, Chapter 13, Section 22.1C for detailed information on election process) unless the care is continuous throughout the subsequent election periods as long as the TRICARE beneficiary remains in the care of the hospice and does not revoke the election.

4. Psychiatric Residential Treatment Centers

a. Care in psychiatric residential treatment centers (RTCs) must be authorized by the contractor before any payment is made. Effective for all admissions occurring on or after December 1, 1988, the TMA-determined rate shall apply to any out-of-region beneficiaries who are admitted to the facility. Refer to the *Policy Manual, Chapter 13*)

b. Before any claims for residential treatment center care can be paid, an authorization must be on file. The dates of service on the claim form and the name of the facility plus the Employer Identification Number (EIN) with suffix must correspond with the dates of the approval and the facility indicated on the authorization. If the beneficiary resides outside of the contractor's region, the contractor responsible for payment shall pay the claims at the rate determined by TMA. When the contractor issues an RTC authorization, it shall flag its files to preclude payment of any family or collateral therapy that is billed in the name of the residential treatment center patient. That cost is the responsibility of the residential treatment center, unless, as part of its negotiated agreement, the contractor agrees to a separate payment for such care. Under the TMA-determined rates, family therapists may bill separately from the residential treatment center (outside the all-inclusive rate) only if the therapy is provided to one or both of the parents residing a significant distance from the RTC. In the case of residents of a region, geographically distant family therapy must be certified by the contractor in order for cost-sharing to occur.

c. ***Reserved***

d. If a claim for admission or extension is submitted and no authorization form is on file, the claim shall not be paid. For network claims, the contractor may deny or develop in accordance with its agreements with network providers. For non-network claims, the contractor shall *deny the claim*.

e. For any claims submitted for inpatient care at other than the residential treatment center, the contractor shall pay the claim if the care was medically necessary. Claims for RTC care during the period of time the beneficiary was receiving care from another inpatient facility shall be denied. If the residential treatment center has been paid and a claim for inpatient hospital care is received and the care was medically necessary, the contractor must pay the inpatient hospital claim and recover the payment from the residential treatment center according to the provisions in OPM Part Two, Chapter 5.

f. ***Reserved***

g. ***Reserved***

5. Dissemination of Information on Authorization Requirements under the *TRICARE* Basic Program

a. General

The contractor is required to advise beneficiaries, sponsors, providers, and other responsible persons of those benefits requiring authorization before payment can be made and of the procedures for requesting this authorization. Although beneficiaries are required to obtain authorization prior to receiving payment for the care listed in Section IV.H.2.a., above, authorization may be requested following the care. Whether the authorization is requested before or after care, all qualified care shall be authorized for payment. *The* contractor shall emphasize the need for concerned persons to contact their health benefits advisor or the Health Care Finder for assistance.

b. Information Required for Authorization Determinations

The contractor shall document authorization according to current contract requirements.

6. Authorization for Grandfathered Custodial Care Cases

A list of the beneficiaries who qualified for custodial care benefits prior to June 1, 1977, has been furnished to each contractor with instructions to flag the file for those beneficiaries on the list who are within their region. Claims received for those beneficiaries, for which no authorization is on file, are to be suspended and the contractor to notify the TMA, *Beneficiary and Provider* Services *Directorate*. Refer to the *32 CFR 199.4*.

7. Payment Reduction

During claims processing, provider payments shall be reduced for failure to comply with the preauthorization requirements for certain types of care. See the Policy Manual, Chapter 13, Section 24.1, and OPM Part Two, Chapter 4, Section IV.

I. *Reserved*

J. Medical Review

1. Requirements for Compliance

The Public Law 89-614 and amendments governing the operation of *TMA*; Chapter 55, Title 10 of the United States Code, require reimbursement of eligible TRICARE beneficiaries and providers for covered services that are medically necessary.

2. *Reserved*

3. Benefit Policy Decisions

a. TRICARE Versus Local Policy

TRICARE policies have precedence over any local or internal policy of the contractor or the medical community of the region where non-Prime enrollees are involved. However, the contractor shall notify TMA promptly of any conflicts between TRICARE policy and local policy. For TRICARE Prime enrollees, variations from policy which simply expand coverage may be implemented without prior approval, but *TMA* must be notified of enhanced coverage at least *thirty (*30*)* days prior to implementation. If benefits are being reduced or adjusted, the change shall be referred to TMA for approval before being implemented.

b. TRICARE Policy Silent

When TRICARE is silent on an issue, the matter shall be referred to TMA for a benefit policy determination. Until a policy is published by TMA covering the specific issue, all claims involving the policy issue must be denied. The policy issuance from TMA will include specific instructions for handling claims when a retroactive determination is made. If the policy determination affects procedures for claims processing, an Operations Manual change will also be issued.

4. *Contractor* Levels of Claims Review

a. First Level Claims Review

Denial determinations based on coverage limitations contained in 32 CFR 199, the TRICARE/CHAMPUS Policy Manual, and other TRICARE guidances, are considered factual determinations. The first level reviewer may approve care, or deny the care, in those cases where they can make a factual determination (i.e., the type of care provided is specifically excluded from the TRICARE Program) and there is no need for a medical necessity determination, or refer the case to second level review if a medical necessity determination is required. At the first level review, basic prepayment screens (automated and manual), are applied to each claim submitted. Such prepayment screens shall include, but not be limited to, the following:

(1) Screening of the claim against the series of diagnoses and related procedure codes which are specific exclusions or limitations of the Program.

(2) Screening of the claim for possible duplicate care and billings. (Refer to Section VI.D. of this chapter.)

(3) Screening of the claim for unusual dollar amounts for a claimed service or supply. (Refer to Section VI.B.5. of this chapter.)

(4) Screening of the claim for excessive utilization of services, supplies, or pharmaceuticals.

b. *Second Level* Review

Second Level Review must be carried out by registered nurses, or equally qualified medically trained staff, who can make medical judgments based on professional education and experience. *(See OPM Part Three, Chapter 3, Section I.A.4.)* This means RNs or qualified Physician's Assistants (PAs), for medical claims; for handling of mental health claims, an RN or PA with mental health training, or a qualified MSW or clinical psychologist. A qualified, graduate pharmacist may be used for prescription drug claims. A qualified LVN, working directly under the close supervision of an RN or PA, may be used, if the contractor submits the LVN's full resume and a detailed scope of authority and responsibility to the Contracting Officer's representative for approval before the LVN assumes a medical review role. These personnel must have a thorough knowledge of medical policy, standards and TRICARE criteria. The contractor shall make documented guidelines available to reviewers for all coverage parameters and medical necessity criteria. The reviewer shall document the rationale for the approval or denial of coverage; i.e., fully state the evidence and the reasons that were the basis for approval or denial. The review must be dated and include the clinical specialty of the reviewer (e.g., R.N., L.P.N.) and the signature and legibly printed name of the reviewer (not initials). Contractors with fully documented guidelines may desire to standardize phraseology for common procedures and recurring types of cases. This is acceptable if the record supports the conclusions that were made. If the initial review personnel cannot make a determination, the claim(s) shall be referred to Medical Review. Either contractor medical staff or an external consultant shall do the review. Use of medical staff and/or consultants is expected and required for not only initial claims processing, but also in appeals or in postpayment analyses. Whenever the case is complex, physician consultants, with a specialty which is appropriate to the case, should be involved in the review. In the case of mental health claims, a staff or consultant physician

must be involved in complex cases and in all mental health case appeals. The physician consultant will carefully review the case and document the rationale for the decision; i.e., fully state the evidence and the reasons that were the basis for approval of denial. The review must be dated and include the clinical specialty of the reviewer (e.g., M.D., D.O.) and signature and legibly printed name of the reviewer. The physician reviewer must document his or her rationale for the approval or denial of coverage in a brief written opinion in the case file. The opinion must be signed (not initialed) by the reviewer. To expedite non-network claims processing and to make more effective use of physician medical advisors, telephone consultations with the advisor may be used if the following provisions are met:

(1) The consultation must be handled by a supervisory level registered nurse medical reviewer or by a physician member of the contractor's advisory staff.

(2) There must be great care taken to prevent misunderstanding of the circumstances of the case and the medical advisor's recommendations.

(3) The matters discussed and the recommendation must be thoroughly documented, including the date, the rationale for the decision/recommendation, the name of the caller and the name of the medical advisor.

(4) The medical advisor who was contacted must review the actual case file and countersign the written decision within ten (10) workdays of the call. The case should not be delayed for the signature.

(5) The use of telephone calls must not be used to replace in-person medical advisor reviews, but to supplement them and to increase the ability to speed processing and to increase involvement of appropriate specialists in effective review of complex cases.

5. ***Reserved***

a. ***Reserved***

(1) ***Reserved***

(2) ***Reserved***

b. ***Reserved***

c. ***Reserved***

6. ***Reserved***

7. ***Reserved***

8. ***Reserved***

9. ***Reserved***